DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Children and Family Services
CFS-2371 (03/2006)

STATE OF WISCONSIN

SUBSIDIZED GUARDIANSHIP HIGH SCHOOL INFORMATION

Use of form: This form is voluntary; however, the information requested must be provided in order to verify that Subsidized Guardianship benefits may continue after the child reaches 18 years of age. Personally identifiable information on this form is used to verify the information necessary for providing benefits and will be used only for this purpose.

Instructions: If additional space is needed, attach a separate sheet.

Name – Child (Last, First, MI)	Birthdate – Child (mm/dd/yyyy)

Name – Father (Last, First, MI)	Name – Mother (Last, First, MI)

Mailing Address – Parent(s) (Street, City, State, Zip Code)

Daytime Telephone Number – Father	Daytime Telephone Number – Mother

Check "Yes" or "No" for each item below.

1. ☐ Yes ☐ No Child is in a full-time high school program.

2. ☐ Yes ☐ No Child will be continuing in a full-time high school program past his / her 18th birthday.
   If "Yes", provide the following information.

Date – High School Graduation	Name – High School

NOTE: Graduation date is needed to evaluate your child's eligibility for Subsidized Guardianship Assistance beyond age 18.

3. ☐ Yes ☐ No Child has entered military service. If "Yes", provide the enlistment date. — Date – Military Enlistment

4. ☐ Yes ☐ No Child is married. If "Yes", provide the date of marriage. — Date – Marriage

5. ☐ Yes ☐ No Is child living with you? If "No", provide the following information.

Date – Child Left Home	Child's Current Living Arrangement (Check one)
	☐ Living independently ☐ Foster Home ☐ Residential Care Center for Children and Youth ☐ Other – Specify:

Address - Child (Street, City, State, Zip Code)

Your Monthly Expenses for Child's Out-of-Home Care

Expense Type	Expense Amount	Expense Type	Expense Amount
	$		$
	$		$
	$		$
	$		$

6. Additional Information

I hereby certify that the information that I have provided is true to the best of my knowledge.

Name – Person Completing Form	Relationship to Child	Date – Form Completed
SIGNATURE – Person Completing Form		Date – Form Signed

Thank you for keeping us informed of changes so we can provide your benefits promptly. If you have further questions, contact the Bureau of Programs and Policies at 1-866-666-5532.

Return completed form to: Subsidized Guardianship Accountant
Department of Health and Family Services
Division of Children and Family Services
Bureau of Programs and Policies
P.O. Box 8916
Madison, WI 53708-8916

FOR OFFICE USE ONLY ☐ GRAD LTR ☐ MA LTR